

Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. The purpose of personal care services is to assist individuals with functional impairments with their daily living activities. Personal care services must be provided in accordance with an approved service plan and supporting documentation. In addition, personal care services must be coordinated with the other Medicaid and non-Medicaid services being provided to the recipient and will be considered in conjunction with those other services.

B. Each recipient requesting or receiving long-term personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the level of care eligibility tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/recipient shall be assessed using a uniform interRAI home care assessment tool or a subsequent assessment tool designated by OAAS. The assessment is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying his/her need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The assessment generates a score which measures the recipient's degree of self-performance of late-loss activities of daily living during the period just before the assessment.

1. The late-loss ADLs include eating, toileting, transferring and bed mobility. An individual's assessment will generate a score which is representative of the individual's degree of self-performance on the late-loss ADLs.

D. Based on the applicant/recipient's uniform assessment score, he/she is assigned to a level of support category and is eligible for a set allocation of weekly service hours associated with that level.

1. If the applicant/recipient is allocated less than 32 hours per week and believes that he/she is entitled to more hours, the applicant/recipient or his/her responsible representative may request a fair hearing to appeal the decision.

2. The applicant/recipient may qualify for more hours if it can be demonstrated that:

- a. one or more answers to the questions involving late-loss ADLs are incorrect as recorded on the assessment; or
- b. he/she needs additional hours to avoid entering into a nursing facility.

E. Requests for personal care services shall be accepted from the following individuals:

1. a Medicaid recipient who wants to receive personal care services;

2. an individual who is legally responsible for a recipient who may be in need of personal care services; or

3. a responsible representative designated by the recipient to act on his/her behalf in requesting personal care services.

F. Each recipient who requests PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without his/her involvement.

b. The written designation is valid until revoked by the recipient. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist or represent, as needed, the recipient in the assessment, care plan development and service delivery processes; and

b. to aid the recipient in obtaining all necessary documentation for these processes.

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

- a. the Program of All-Inclusive Care for the Elderly;
- b. long-term personal care services;
- c. the community choices waiver; and
- d. the adult day health care waiver.

G. The Department of Health may remove an LT-PCS provider from the LT-PCS provider freedom of choice list and offer freedom of choice to LT-PCS participants when:

1. one or more of the following departmental proceedings are pending against a LT-PCS participant's service provider:

- a. revocation of the provider's home and community-based services license;
- b. exclusion from the Medicaid Program;
- c. termination from the Medicaid Program; or
- d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the service provider's assets have been seized by the Louisiana Attorney General's office.

H. The department may offer recipients the freedom to choose another provider if/when the owner(s), operator(s), or member(s) of the governing body of the provider agency is/are under investigation related to:

1. bribery or extortion;
2. tax evasion or tax fraud;
3. money laundering;
4. securities or exchange fraud;
5. wire or mail fraud;
6. violence against a person;
7. act(s) against the aged, juveniles or infirmed; or
8. any crime involving public funds.

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§12903. Covered Services

A. *Personal care services* are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by him/herself. ADLs are those personal, functional activities required by the recipient. ADLs include tasks such as:

1. eating;
2. bathing;
3. dressing;
4. grooming;
5. *transferring*—the manner in which an individual moves from one surface to another (excludes getting on and off the toilet, and getting in and out of the tub/shower);
6. ambulation;

7. toileting; and

8. bed mobility.

B. IADLs are those activities that are considered essential but may not require performance on a daily basis. IADLs cannot be performed in the recipient's home when he/she is absent from the home. IADLs include tasks such as:

1. light housekeeping;
2. food preparation and storage;
3. shopping;
4. laundry;
5. assisting with scheduling medical appointments when necessary;
6. accompanying the recipient to medical appointments when necessary;
7. assisting the recipient to access transportation; and
8. reminding the recipient to take his/her medication as prescribed by the physician; and
9. medically non-complex tasks where the direct service worker has received the proper training pursuant to R.S. 37:1031-1034.

C. Emergency and nonemergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is not a required component of personal care services. However, providers may choose to furnish transportation for recipients during the course of providing personal care services. If transportation is furnished, the provider agency must accept any liability for their employee transporting a recipient. It is the responsibility of the provider agency to ensure that the employee has a current, valid driver's license and automobile liability insurance.

D. Constant or intermittent supervision and/or sitter services are not a component of personal care services.

E. For participants receiving LT-PCS with the Adult Day Health Care (ADHC) Waiver, personal care services may be provided by one worker for up to three long-term personal care service recipients who live together, and who have a common direct service provider.

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§12905. Eligibility Criteria

A. Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and have a disability. Persons with a disability must meet the disability criteria established by the Social Security Administration.

B. Recipients must meet the eligibility criteria established by OAAS or its designee. Personal care services are medically necessary if the recipient:

1. meets the medical standards for admission to a nursing facility and requires limited assistance with at least one or more activities of daily living;

2. is able, either independently or through a responsible representative, to participate in his/her care and direct the services provided by the personal care services worker. A responsible representative is defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services; and

3. faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if:

- a. the recipient is in a nursing facility and could be discharged if community-based services were available;

- b. is likely to require nursing facility admission within the next 120 days; or

- c. has a primary caregiver who has a disability or is over the age of 70.

C. Persons designated as the responsible representative of an individual receiving services under LT-PCS may not be the paid direct service worker of the individual they are representing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:903 (June 2016).

§12907. Recipient Rights and Responsibilities

A. Recipients who receive services under the Long-Term Personal Care Services Program have the right to actively participate in the development of their plan of care and the decision-making process regarding service delivery. Recipients also have the right to freedom of choice in the selection of a provider of personal care services and to participate in the following activities:

1. interviewing and selecting the personal care worker who will be providing services in their home;

2. developing the work schedule for their personal care worker;

3. training the individual personal care worker in the specific skills necessary to maintain the recipient's independent functioning while maintaining him/her in the home;

4. developing an emergency component in the plan of care that includes a list of personal care staff who can serve as back-up when unforeseen circumstances prevent the regularly scheduled worker from providing services;

5. signing off on payroll logs and other documentation to verify staff work hours and to authorize payment;

6. evaluating the personal care worker's job performance; and

7. changing the personal care worker assigned to provide their services;

8. an informal resolution process to address their complaints and/or concerns regarding personal care services; and

9. a formal resolution process to address those situations where the informal resolution process fails to resolve their complaint.

B. Changing Providers. Recipients may request to change PCS agencies without cause once after each three month interval during the service authorization period. Recipients may request to change PCS providers with good cause at any time during the service authorization period.

Good Cause—the failure of the provider to furnish services in compliance with the plan of care. *Good cause* shall be determined by OAAS or its designee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:903 (June 2016).

§12909. Standards for Participation

A. In order to participate as a personal care services provider in the Medicaid Program, an agency:

1. must comply with:

- a. state licensing regulations;

- b. Medicaid provider enrollment requirements;

- c. the standards of care set forth by the Louisiana Board of Nursing; and

- d. any federal or state laws, rules, regulations, policies and procedures contained in the Medicaid provider

manual for personal care services, or other document issued by the department. Failure to do may result in sanctions;

2. must possess a current, valid home and community-based services license to provide personal care attendant services issued by the Department of Health, Health Standards Section.

B. In addition, a Medicaid enrolled agency must:

1. maintain adequate documentation as specified by OAAS, or its designee, to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department or its designee; and

2. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations.

C. An LT-PCS provider shall not refuse to serve any individual who chooses his agency unless there is documentation to support an inability to meet the individual's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. OAAS or its designee is charged with the responsibility of setting the standards, monitoring the outcomes and applying administrative sanctions for failures by service providers to meet the minimum standards for participation.

1. Failure to meet the minimum standards shall result in a range of required corrective actions including, but not limited to:

- a. removal from the Freedom of Choice listing;
- b. a citation of deficient practice;
- c. a request for corrective action plan; and/or
- d. administrative sanctions.

2. Continued failure to meet the minimum standards shall result in the loss of referral of new LT-PCS recipients and/or continued enrollment as an LT-PCS provider.

E. Electronic Visit Verification. An electronic visit verification (EVV) system must be used for automated scheduling, time and attendance tracking and billing for LT-PCS services.

1. LT-PCS providers identified by the department shall use:

- a. the EVV system designated by the department; or
- b. an alternate system that:
 - i. has successfully passed the data integration process to connect to the designated EVV system; and

ii. is approved by the department.

2. Reimbursement for services may be withheld or denied if a provider:

a. fails to use the EVV system; or

b. uses the system not in compliance with Medicaid's policies and procedures for EVV.

3. Requirements for proper use of the EVV system are outlined in the respective program's Medicaid provider manual. All LT-PCS providers shall comply with the respective program's Medicaid provider manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2508 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1980 (October 2017).

§12911. Staffing Requirements

A. All staff providing direct care to the recipient must meet the qualifications for furnishing personal care services per the licensing regulations. The direct service worker shall demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to these recipients, and the maturity and ability to deal effectively with the demands of the job.

B. Restrictions

1. The following individuals are prohibited from being reimbursed for providing services to a recipient:

- a. the recipient's spouse;
- b. the recipient's curator;
- c. the recipient's tutor;
- d. the recipient's legal guardian;
- e. the recipient's designated responsible representative; or
- f. the person to whom the recipient has given representative and mandate authority (also known as Power of Attorney).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:903 (June 2016).

§12913. Service Delivery

A. Personal care services shall be provided in the recipient's home or in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. The recipient's home is defined as the place where he/she resides such as a house, an apartment, a boarding house, or the house or apartment of a family member or unpaid primary care-giver. IADLs cannot be performed in the recipient's home when the recipient is absent from the home.

B. The provision of services outside of the recipient's home does not include trips outside of the borders of the state without approval of OAAS or its designee.

C. Participants are not permitted to live in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support worker is related by blood or marriage to the participant.

1. The provisions of §12913.C may be waived with prior written approval by OAAS or its designee.

D. Place(s) of service must be documented in the plan of care and service logs.

E. It is permissible for an LT-PCS recipient to use his/her approved LT-PCS weekly allotment flexibly provided that it is done so in accordance with the recipient's preferences and personal schedule and is properly documented in accordance with OAAS policy.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), LR 41:541 (March 2015), LR 42:903 (June 2016).

§12915. Service Limitations

A. Personal care services shall be limited to up to 32 hours per week. Authorization of service hours shall be considered on a case-by-case basis as substantiated by the recipient's plan of care and supporting documentation.

B. There shall be no duplication of services.

1. Personal care services may not be provided while the recipient is admitted to or attending a program which provides in-home assistance with IADLs or ADLs or while the recipient is admitted to or attending a program or setting where such assistance is available to the recipient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2509 (September 2013).

§12917. Unit of Reimbursement

A. Reimbursement for personal care services shall be a prospective flat rate for each approved unit of service that is provided to the recipient. One quarter hour (15 minutes) is the standard unit of service for personal care services. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service. Additional reimbursement shall not be available for transportation furnished during the course of providing personal care services.

B. The minimum hourly rate paid to personal care workers shall be at least the current federal minimum.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:3267 (November 2011), LR 39:1780 (July 2013), LR 42:904 (June 2016).

§12919. Cost Reporting Requirements

A. Effective July 1, 2012, the department shall implement mandatory cost reporting requirements for providers of long-term personal care services. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to Medicaid recipients.

B. Each LT-PCS provider shall complete the DHH approved cost report and submit the cost report(s) to the department no later than five months after the state fiscal year ends (June 30).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

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